STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G700		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 02/25/2013		
NAME OF P	ROVIDER OR SUPPLIEF				ADDRESS, CITY, STATE, ZIP CODE RKANSAS AVE		
ARC OF	NORTHWEST IND	IANA INC, THE	HAMMOND, IN 46323				
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES	ID PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
W000000							
	This visit was for an annual recertification and state licensure survey.		W0	00000			
	Dates of survey: 2013.	February 5, 6, 7 and 25,					
	Facility number: 003148						
	Provider number: 15G700						
	AIM number: 2	00360500					
	Surveyor Team:	Christine Colon,					
	_	or III/QMRP-Team					
	Leader	a					
	Paula III/QMRP	Chika, Medical Surveyor					
	-	Rowe, Federal Surveyor					
		·· •, - • • • · · · · · · · · · · · · · · · ·					
	_	eficiencies also reflect accordance with 460 IAC					
		completed March 8, 2013 n, Medical Surveyor III.					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

003148

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLE			ETED	
		15G700	A. BUII B. WIN			02/25/	2013
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				RKANSAS AVE		
ARC OF	NORTHWEST INDI	ANA INC. THE	HAMMOND, IN 46323				
		·			1		
(X4) ID		FATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX		(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE		DATE
W000104	4 483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over						
	the facility.	an operating an obtain over					
	Based on record review and interview, for		W0	00104	Pharmacy reviews will be		03/27/2013
		iding at the group home			addressed within 30 days of	of	
	(clients #1, #2, #3 and #4), the governing body failed to exercise general policy and operating direction over the facility to ensure the facility				receiving them. To ensure futu		
					compliance, Nursing Manager		
					review Pharmacy reviews with 30days of receiving them and	111	
					thereafter.		
	developed/implemented policy and procedures in regards to assuring						
		acist reviews were					
	conducted and re	eviewed by the physician.					
	Findings include	÷					
	1 111411185 11141444	•					
	Client #1's record	d was reviewed on 2/6/13					
		ient #1's December 2012					
		rs indicated client #1					
		medications which					
		rex (iron supplement),					
	•	chlorthiazide (blood					
	pressure) and Se						
	(hydrochloride) ((behavior). Client #1's					
	record indicated	no quarterly pharmacy					
		n conducted in regard to					
		cations for the 2012					
	calendar year.						
	carondar year.						
	Δ review of clien	nt #2's record was					
		6/13 at 12:23 P.M. Client					
		t physician's order dated					
	2/13 indicated sh	ne received routine					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
		15G700	B. WIN			02/25/2013	
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
4 DO OF	NODEL WATER IND	IANIA INIC. THE			RKANSAS AVE		
ARC OF	NORTHWEST IND	IANA INC, THE		HAMMC	OND, IN 46323		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		
TAG	medications which consisted of			TAG	BEI ICIENCT)	DATE	
	Thiothixene (Bipolar), Travatan (eye						
	· •	, · · · · · · · · · · · · · · · · · · ·					
		ophen (pain), Maalox					
	`	eudoephedrine (nasal					
		pafen (cough) and					
	`	ea). Review of the					
	record did not in						
		vs had been conducted in					
	regard to the client's medications for the						
	2012 calendar ye	ear.					
		ord review was initiated					
		er physician's order,					
	· ·	cumented she was					
		cations including					
	· ·	roxyprogesterone,					
		umetone, Potassium,					
	Saphris, Tizanid	-					
	•	e. The record did not					
		ly drug regimen review					
		e pharmacist for the 2012					
	calendar year.						
		nt #4's record was					
		6/13 at 4:00 P.M. Review					
		st current physician's					
		indicated she received					
		ons which consisted of					
		olar), Fluticasone (nasal					
	1 3// 3	eizures), Folic acid					
	, , , , , , , , , , , , , , , , , , ,	bazepine (seizures),					
	Acetaminophen	4 //					
		l Pseudoephedrine (nasal					
	congestion). Re	eview of client #4's record					

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	AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G700		00	COMPLETED 02/25/2013		
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 7318 ARKANSAS AVE HAMMOND, IN 46323				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE COMPLETION		
	did not indicate quarterly pharmacy reviews had been conducted in regard to the client's medications for the 2012 calendar year.					
	On 2/6/13 at 11:50 a.m. an interview was initiated with the Director of Nursing. She reported the agency did not have evidence of the required quarterly pharmacy reviews for the residents of the facility. She indicated the agency had experienced failures in obtaining quarterly pharmacy review reports and failures in nursing staff follow up to assure the reports were received and reviewed by the physician. 9-3-1(a)					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	COMPLETED			
		15G700	B. WING		02/25/2013		
				ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	ROVIDER OR SUPPLIE	R					
ARC OF	NORTHWEST IND	IANA INC. THE	7318 ARKANSAS AVE HAMMOND, IN 46323				
				1			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)		
PREFIX	· ·		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)			
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE		
W000111	483.410(c)(1)	IDC					
	CLIENT RECOR						
		develop and maintain a stem that documents the					
		re, active treatment, social					
		protection of the client's					
	rights.	F					
	Based on intervi	iew and record review for	W000111	Screenings for extra pyramida	03/27/2013		
	1 of 2 sampled clients (client #2) and 1 additional client (client #3), the facility			are done during nursing quarte	erly		
				physical assessment and mos	t		
		all pertinent information		Psychiatric appointments.To			
		•		ensure future compliance,			
	_	n client's health was part		Service Coordinator will audit Master files bi-annually and			
	of the client's ch	nart/records.		thereafter and attend psychiat	ric		
				appointments.			
	Findings include	2 :					
	A review of clie	ent #2's record was					
	conducted on 2/	6/13 at 12:23 P.M. A					
		nysician's order dated					
		ed she was prescribed					
	-	•					
		a treatment for bipolar					
		dence existed in the					
		nent ongoing screening for					
	extrapyramidal s	side effects of the use of					
	Thiothixene.						
	On 2/6/13 at 4·0	00 P.M., the Service					
		C) provided the surveyor					
	`	t which she identified as a					
	_	nent for side effects of					
		edication that was given to					
	her by the nurse	to provide to the					
	surveyor. The d	locument was labeled,					
	"Braden Scale fo	or Predicting Pressure					
		included a scoring system					
	unu i						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G700	B. WIN			02/25/	2013
NAME OF P	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUFFLIER			7318 AF	RKANSAS AVE		
ARC OF	NORTHWEST IND	IANA INC, THE		HAMMC	OND, IN 46323		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX			COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)	DATE	
	to evaluate skin integrity issues. No						
		ening for extrapyramidal					
	side effect of psychoactive medication was provided.						
	A marria £ -1: -						
	A review of client #3's record was conducted on 2/6/13. Her physician's						
		13, documented she was					
	prescribed Saphris as a treatment for						
	bipolar disorder. No evidence existed in						
	the record to document ongoing screening						
		lal side effects of the use					
	of Saphris.						
	On 2/6/12 at 1:1	5 P.M. an interview was					
		aff #7, the Licensed					
		assigned to monitor the					
		ople in the facility. She					
		nce of ongoing screening					
		lal side effects of					
	1 ^ -	edication for Client #3.					
	1	chiatrist screened patients					
	1	lal side effects of					
	1 * *	edications at annual and					
		ointments. She said the					
	^ -	the AIMS (Abnormal					
	I -	vement Scale) to conduct					
		She verified the screening					
		not in the client records,					
	adding the docur	ments were on her desk.					
	0.2.1(a)						
	9-3-1(a)						

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	OF CORRECTION	IDENTIFICATION NUMBER: 15G700	(X2) MULTIPLE CC A. BUILDING B. WING	00	— COMP 02/25	LETED 5/2013		
ARC OF	PROVIDER OR SUPPLIER	IANA INC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 7318 ARKANSAS AVE HAMMOND, IN 46323					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G700		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 02/25/2013		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 7318 ARKANSAS AVE HAMMOND, IN 46323				
			ID		JND, IN 1 0020		(7/5)
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W000130	The facility must of clients. Therefore privacy during trepersonal needs. Based on observing facility failed to clients in regard additional client home (client #3) Findings include During the 2/5/1 between 5:45 AM group home, client home, client home underwear are up. Staff #9, who hallway and glart bedroom, did not client #3 to close protect the client Interview with the 2/7/13 at 9:40 AM should close and	residing at the group 3 observation period M and 8:40 AM, at the ent #3 sat on the floor in and nude from the waist o walked down the need into client #3's t close and/or redirect e her bedroom door to	W0	00130	Service Coordinator will implement a formal training objective for client #3 to close doors when dressing/undressi. This training will be done throudemonstration. Staff will also be trained on assisting clients in maintaining their privacy. To ensure future compliance, Service Coordinator will monit twice monthly thereafter.	ugh De	03/27/2013

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G700		A. BUILDING B. WING	00	COMPLETED 02/25/2013					
	PROVIDER OR SUPPLIEI NORTHWEST IND		STREET ADDRESS, CITY, STATE, ZIP CODE 7318 ARKANSAS AVE HAMMOND, IN 46323						
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE S	3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	a. BUILDING 00			COMPLETED	
		15G700	B. WIN			02/25/	2013
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 7318 ARKANSAS AVE HAMMOND, IN 46323				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDENCE NAME OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	16	DATE
W000136	483.420(a)(11) PROTECTION O The facility must of clients. Therefore that clients have to participate in soci community group Based on intervir facility failed to out of home soci 2 of 2 sampled count and for 2 addition #4). Findings include Interview with country and indicated shing the community if client #3 would client #3 modded Client #1's record 12:57 PM. Client Services daily loo 1/31/13 indicated participated in country and/or outings as documented community to review for the A review of client conducted on 2/6 #2's record did not service with a review of client conducted on 2/6 #2's record did not service with a review of client conducted on 2/6 #2's record did not service with a review of client conducted on 2/6 #2's record did not service with a review of client conducted on 2/6 #2's record did not service with a review of client conducted on 2/6 #2's record did not service with a review of client conducted on 2/6 #2's record did not service with a review of client conducted on 2/6 #2's record did not service with a review of client conducted on 2/6 #2's record did not service with a review of client conducted on 2/6 #2's record did not service with a review of client conducted on 2/6 #2's record did not service with a review of client conducted on 2/6 #2's record did not service with a review of client conducted on 2/6 #2's record did not service with a review of client conducted on 2/6 #2's record did not service with a review of client conducted with a review of c	F CLIENTS RIGHTS ensure the rights of all e, the facility must ensure the opportunity to tal, religious, and activities. ew and record review the provide opportunities for al and group activities for lients (clients #1 and #2) nal clients (clients #3 and c: lient #3 on 2/5/13 at 7:42 e had not been shopping by recently. When asked d like to go shopping, her head, yes. d was reviewed 2/6/13 at at #1's Residential gs from 11/1/12 to d client #1 had not community activities	W0	00136	3/27/13The Service Coordinate will train group home staff to properly and document all outings on a calendar and to plan and complete weekend plans to be sent in weekly. To ensure future compliance, Service Coordinate will review weekly for three months and monthly thereafter with additional training if needed.	lan ere tor	03/27/2013

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G700		(X2) MULTIPLE CO A. BUILDING B. WING	00	COME	(X3) DATE SURVEY COMPLETED 02/25/2013			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 7318 ARKANSAS AVE HAMMOND, IN 46323					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
	and/or outings as documented outi for the calendar	ngs/activities to review						
	for Client #3. N record of social,	ord review was initiated to evidence existed in her shopping or community ities documented by the						
	conducted on 2/0 #4's record did n participated in an and/or outings as	ngs/activities to review						
	PM stated client to go into the co Staff #8 stated "I time." When asl	taff #8 on 2/5/13 at 6:22 s #1, #2, #3 and #4 used mmunity "all the time." Not as much in winter ked where community s were documented, staff gs."						
	initiated with the Retardation Prof the facility as the She reported the place to provide community integ	O p.m. an interview was e Qualified Mental essional (referred to by e Service Coordinator). agency had a system in and document grating activities provided absence of documentation						

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	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 15G700	(X2) MULTIPLE CO A. BUILDING B. WING	00	— COM	TE SURVEY MPLETED 25/2013		
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 7318 ARKANSAS AVE HAMMOND, IN 46323					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
	of such activities provided for clients #1, #2, #3 and #4 who resided at the facility.						
	9-3-2(a)						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		15G700	A. BUILDING B. WING		02/25/2013
	PROVIDER OR SUPPLIEI		7318 A	ADDRESS, CITY, STATE, ZIP CODE RKANSAS AVE OND, IN 46323	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
W000137	The facility must clients. Therefore that clients have appropriate persocal clothing. Based on observation facility failed to activities while approgram, for 1 of #2). Findings included A facility owned was conducted of A.M. until 1:25 Direct Support I handed client #2 children's puzzle play with the puprovided any of observation. An interview with Coordinator (SC	d day program observation on 2/5/13 from 11:10 P.M. At 11:30 A.M., Professional (DSP) #8 2 a large wooden a and prompted her to zzle. Client #2 was not her activities during the the the Service C) was conducted on M. The SC indicated be offered age	W000137	The Developmental Specialist has trained staff over active treatment. Staff will work with clients at 5 minute intervals throughout the day with age appropriate materials. Developmental Specialist has removed all inappropriate materials from the rooms. To ensure future compliance, Service Coordinator will monit bi-weekly and thereafter. Developmental Specialist will monitor on a daily basis with continuous training as needed	or

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	OF CORRECTION	IDENTIFICATION NUMBER: 15G700	A. BUILDING B. WING	00	COMI	PLETED 5/2013	
ARC OF	ROVIDER OR SUPPLIER	IANA INC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 7318 ARKANSAS AVE HAMMOND, IN 46323				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE // DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	

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NAME OF PROVIDER OR SUPPLIER	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY
NAME OF PROVIDER OF SUPPLIER ARC OF NORTHWEST INDIANA INC, THE (XV) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) W000159 43,430(a) OUALIFIED MENTAL RETARDATION PROFESSIONAL Each clients active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional (QMRP) did not integrate social activities, did not coordinate staff training or monitor programs for clients at the facility's day program to ensure they contained program methodologies, criteria for attainment, were revised as needed, and were implemented. Findings include: 1. Please refer to W136. The QMRP failed to provide opportunities for out of home social and group activities for 4 of 4 clients (Client #1, #2, #3 and #4). 2. Please refer to W137 for the QMRP's failure to monitor the facility's day program to ensure age appropriate activities were provided, for 1 of 2	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUILDI	A BUILDING 00		COMPLETED	
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE (X4) ID SIMMARY SEATEMENT OF DEFICINCIES (X5) IN SIMMARY SEATEMENT OF DEFICINCIES (X6) IN SIMMARY SEATEMENT OF DEFICEMENT OF SEATEMENT OF SEATEME			15G700				02/25/	2013
ARC OF NORTHWEST INDIANA INC, THE ARC OF NORTHWEST INDIANA INC, THE THE NAME OF STATE OF					STREET A	DDRESS CITY STATE ZIP CODE		
ARC OF NORTHWEST INDIANA INC, THE HAMMOND, IN 46323	NAME OF P	ROVIDER OR SUPPLIER	1					
NA 10 PREFIX GEACH DEFICIENCY MUST BE PRECEDED BY FILL TAG PREFIX T	ABC OF		IANIA INIC THE					
PREFIX TAG CREATED CENTENCY MINTS BE PRECEDED BY FULL REGULATORY OF LIST IDENTIFYING INFORMATION) TAG	ARC OF	NORTHWEST INDI	ANA INC, TTE		TIAWW	JND, IN 40323		
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 483-430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on observation, record review and interview for 4 of 4 clients residing at the home (clients #1, #2, #3 and #4), the facility's Qualified Mental Retardation Professional (QMRP) did not integrate social activities, did not coordinate staff training or monitor programs for clients at the facility's day program, did not integrate communication training in Individual Support Plans (ISPs), and the QMRP failed to monitor clients' programs to ensure they contained program methodologies, criteria for attainment, were revised as needed, and were implemented. Findings include: 1. Please refer to W136. The QMRP failed to provide opportunities for out of home social and group activities for 4 of 4 clients (Client #1, #2, #3 and #4). 2. Please refer to W137 for the QMRP's failure to monitor the facility's day program to ensure age appropriate activities were provided, for 1 of 2	(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
W000159 483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on observation, record review and interview for 4 of 4 clients residing at the home (clients #1, #2, #3 and #4), the facility's Qualified Mental Retardation Professional (QMRP) did not integrate social activities, did not coordinate staff training or monitor programs for clients at the facility's day program, did not integrate communication training in Individual Support Plans (ISPs), and the QMRP failed to monitor clients' programs to ensure they contained program methodologies, criteria for attainment, were revised as needed, and were implemented. Findings include: 1. Please refer to W136. The QMRP failed to provide opportunities for out of home social and group activities for 4 of 4 clients (Client #1, #2, #3 and #4). 2. Please refer to W137 for the QMRP's failure to monitor the facility's day program to ensure age appropriate activities were provided, for 1 of 2	PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX		CROSS-REFERENCED TO THE APPROPRIAT	ΤE	COMPLETION
OUALIFEO MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on observation, record review and interview for 4 of 4 clients residing at the home (clients #1, #2, #3 and #4), the facility's Qualified Mental Retardation Professional (QMRP) did not integrate social activities, did not coordinate staff training or monitor programs for clients at the facility's day program, did not integrate communication training in Individual Support Plans (ISPs), and the QMRP failed to monitor clients' programs to ensure they contained program methodologies, criteria for attainment, were revised as needed, and were implemented. Findings include: 1. Please refer to W136. The QMRP failed to provide opportunities for out of home social and group activities for 4 of 4 clients (Client #1, #2, #3 and #4). 2. Please refer to W137 for the QMRP's failure to monitor the facility's day program to ensure age appropriate activities were provided, for 1 of 2	TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	Т	TAG	DEFICIENCY)		DATE
		483.430(a) QUALIFIED MEN PROFESSIONAL Each client's active be integrated, coordinated and clients and collections and clients and collections are program to ensure activities and collections and collections are program to ensure activities and collections are program to ensure activities are professional and collections are program to ensure activities and collections are program to ensure activities are program to ensu	ATAL RETARDATION We treatment program must predinated and monitored by I retardation professional. ation, record review and of 4 clients residing at the 1, #2, #3 and #4), the ed Mental Retardation MRP) did not integrate did not coordinate staff for programs for clients at 1 program, did not 1 inication training in 1 port Plans (ISPs), and the 1 monitor clients' programs pontained program 1 eriteria for attainment, 1 needed, and were 1. **Co W136.** The QMRP opportunities for out of 1 group activities for 4 of			The Developmental specialist trained staff over active treatment. Staff will work with clients at 5 minute intervals throughout the day with age appropriate materials. Developmental Specialist has removed all inappropriate materials from the rooms. To ensure future compliance, Service Coordinator will monito bi-weekly and thereafter. Developmental Specialist will monitor on a daily basis. See # 136,137,189,227,231,249,240.	OF.	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		15G700	B. WIN			02/25/2013
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
400.05	NODEL WATER IND	IANIA INIO TUE			RKANSAS AVE	
	ARC OF NORTHWEST INDIANA INC, THE			HAMMI	OND, IN 46323	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
1710		o W189. The QMRP		1710	<u> </u>	DATE
		initial and continuing				
		e staff competence in the				
		es intended to prevent				
	1	tion. This failure had the				
		et all clients living in the				
	facility (#1, #2, #	•				
		- , - , <i>)</i> ·				
	4. The QMRP fa	ailed to address the				
	clients' identified training needs in regard					
	to privacy and co	ommunication for clients				
	#1 and #2. Pleas	se see W227.				
	5. The QMRP fa	ailed to ensure client #1's				
		ort Plan (ISP) objectives				
	included specific	c criteria for completion.				
	Please see W231					
	,	ailed for 1 of 2 sampled				
		nsure methods were				
		t #1's Individual Support				
	` /	sure facility staff knew				
		supervise the client at the				
	1 1 0 1	prevent the client from				
	-	rash, from taking others'				
		earching for food. The				
	-	ensure the client's ISP				
		cility staff were to get				
		d scheduled doctor's				
	appointments. P	Tlease see W 240.				
	7 The OMDD S	ailed to engure feeilite				
	,	ailed to ensure facility				
	•	ed clients (#1 and #2's)				
	program pians/o	bjectives when formal				

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G700	(X2) MU A. BUIL B. WINC	DING	NSTRUCTION 00	(X3) DATE COMPL 02/25/	ETED
	PROVIDER OR SUPPLIER			7318 AF	DDRESS, CITY, STATE, ZIP CODE RKANSAS AVE DND, IN 46323		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	_	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE
TAU		training opportunities		TAG			DATE
	objectives after 1	niled to revise clients' no progress had been \$1. Please see W257.					
	9-3-3(a)						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G700			LDING	ONSTRUCTION 00	(X3) DATE : COMPL 02/25 /	ETED	
	ROVIDER OR SUPPLIER			7318 AF	ADDRESS, CITY, STATE, ZIP CODE RKANSAS AVE DND, IN 46323		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
W000186	care staff to mana accordance with toplans. Direct care staff a on-duty staff calce 24-hour period for living unit. Based on observer record review the sufficient direct of supervise 3 of 3 workshop (Client Findings include On 2/5/12 betwee p.m. observation facility owned we clients #1, #3, and (clients) were entitalking, and so tables looking do Forty clients and present. Two of engaged in check with eyeglasses' in plastic sleeves members (Staff # on the telephone while making masheets of paper.	provide sufficient direct age and supervise clients in their individual program are defined as the present ulated over all shifts in a reach defined residential ation, interview and a facility failed to provide care staff to manage and clients attending the ts #1, #3 and #4).	W0	00186	Work shop manager has rearranged staff lunch schedul (10:1) at all times of the day in pre-voc area. 3/27/13 So that ratio of (10:1) is maintained. Tensure future compliance, workshop manager will monito on a daily basis and rearrange schedules as needed.	the a o	03/27/2013

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	OO	(X3) DATE : COMPL		
ANDILLAN	OI CORRECTION	15G700		LDING	00	02/25/	
		100700	B. WIN		PPPPG GWW GW == ===	02/23/	2010
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE RKANSAS AVE		
ARC OF	NORTHWEST INDI	ANA INC, THE			OND, IN 46323		
(X4) ID		TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		t at tables. There were					
		ers in the room, only two					
		providing direct supports					
		present. At 11:25 a.m.					
		ents present and 3 staff					
	,	of 1 staff to 13 clients), at					
		were 42 clients and 3					
	,	ation of 1 to 14), and at					
		were 39 clients and 3					
	staff (ratio of 1 to	-					
		aff and clients left the					
		e lunch room, leaving 1					
		shop with 28 clients					
	` ′	. The staff member					
	_	d (Staff #3) had a					
	•	d between her ear and her					
		s engaged in a telephone					
	conversation. St						
		from a stack of papers on					
		of her as she carried on a					
	-	rsation. She did not					
		‡1 rose from a table					
		d walked to a trash can					
		aff member's desk in the					
		leaned over the trash can					
	_	nrough it. She removed a					
		which she used to wipe					
		an inside her nostrils.					
		see this incident as she					
	•	ak on the phone and					
	attend to the pap	ers on her desk.					
	At 12:50 p.m. the	ere were 3 staff and 37					
	clients (ratio of 1	staff to 11 clients).					

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G700	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM	te survey ipleted 25/2013	
	PROVIDER OR SUPPLIEI NORTHWEST IND		STREET ADDRESS, CITY, STATE, ZIP CODE 7318 ARKANSAS AVE HAMMOND, IN 46323				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
	clients (ratio of At 1:05 p.m. the clients (ratio of At 1:10 p.m. the clients (ratio of On 2/5/13 at 1:1 initiated with St herself as the W said the staffing established as 1 clients. She exp and clients in the move in and out She verified not rummaging thro removing a discher nose/cleanin verified there we in the room to be	lere were 3 staff and 39 1 staff to 13 clients). re were 3 staff and 38 1 staff to 12 clients). re were 1 staff and 38 1 staff to 19 clients). 5 p.m. an interview was aff #3. She identified orkshop Manager. She ratio at the workshop was staff member to every 10 clained the number of staff to room varies as people of the workshop room. seeing Client #1 ugh the trash can, arded tissue and wiping g her nostrils with it. She ere too few staff present to able to effectively went Client #1 from the trash cans.					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G700		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE : COMPL 02/25 /	ETED	
	ROVIDER OR SUPPLIER		B. WIN	7318 AF	ADDRESS, CITY, STATE, ZIP CODE RKANSAS AVE OND, IN 46323	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
W000189	with initial and co enables the employer duties effectively, competently. Based on observer record review the initial and continuitial and continuitial and continuitial and continuitial and contamination. To potential to affect workshop (client workshop (client Findings include On 2/5/12 betwee p.m. observation facility owned where 12:15 p.m. an obtic lunch room a workshop. Client eating her lunch spilled from here Staff #2 (Direct stapproached the the drool spill with a gloves on each here the sample) sat a one of them spill onto the table be moved to that tall	provide each employee intinuing training that oyee to perform his or her efficiently, and ation, interview and a facility failed to provide using training to assure in the use of latex to prevent cross This failure had the at all clients attending the is #1, #3 and #4).	W0	00189	The health and Safety Tech haretrained all staff on infection control, cross contamination, athe use of gloves. Gloves will be available at Health and Safety Techs office, in the cafeteria, the kitchen area during lunch for staff to use as needed. To ensure future compliance, Health and Safety Tech will monitor of daily basis and train staff as needed. New staff will be train before they start working.	and oe and time alth on a	03/27/2013

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G700		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/25/2013	
	PROVIDER OR SUPPLIED NORTHWEST IND		7318 AF	ADDRESS, CITY, STATE, ZIP CODE RKANSAS AVE DND, IN 46323	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	through counter and the kitchen back to the couractivity in the diwatching, she please the counter top a against the under She continued to client, assisting without changin At 12:15 p.m. as Staff #2, Staff # (still gloved) to five" onto Clien On 2/5/13 at 12: initiated with St wore gloves to, She indicated the sanitation. Whe failure on her particular before coming in clients and the "contaminated glows are right, I should have." A training on the waid she had been past, but was not that training. On 2/5/13 at 1:0	s Client #1 approached 2 raised her right hand give Client #1 a "high			

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	OF CORRECTION IDENTIFICATION NUMBER: 15G700	A. BUILDING B. WING	00	COMPLETED 02/25/2013
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	7318 ARK	DRESS, CITY, STATE, ZIP CODE CANSAS AVE ID, IN 46323	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
	Safety Tech. for the workshop. She reported she served as the trainer for the facility on all health/safety related topics. She said she trained the staff annually on Universal Precautions. She said it had been about 12 months since the previous training. She indicated that she discussed the purpose and use of latex gloves in her Universal Precautions training. Staff #5 said she had little opportunity to do continuing observation and training on the staff's use of latex gloves during the mealtime, due to her other duties including passing medications at midday. On 2/7/13 the facility provided records of the subject matter for the Universal Precautions training. These training documents included no written information about the appropriate use of latex gloves. The training materials included a picture of woman holding her hand up, wearing a latex glove on her hand. 9-3-3(a)			

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	T OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA DF CORRECTION IDENTIFICATION NUMBER: 15G700	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM 02/2	e survey pleted 5/2013	
	ROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 7318 ARKANSAS AVE HAMMOND, IN 46323				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DINC	00	COMPLETED	
		15G700				02/25/2013	
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER	L.			ADDRESS, CITY, STATE, ZIP CODE		
ADC OF		IANIA INC. THE			RKANSAS AVE		
ARC OF	NORTHWEST INDI	IANA INC, THE		ПАІМІМ	OND, IN 46323		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W000227	483.440(c)(4)						
	INDIVIDUAL PRO						
		ogram plan states the					
		s necessary to meet the					
	client's needs, as						
	paragraph (c)(3)	ssessment required by					
			13370	00227	The Service Coordinator will		03/27/2013
		ation, interview and	WU	00227	implement a formal training go	nal	03/4//2013
	record review, th				on privacy for clients # 1 & 2		
		teams (IDTs) failed to			ensure future compliance,	*	
		ts' identified training			Service Coordinator will monitor	or	
	needs in regard t	o privacy and			bi-weekly for one month and		
	communication f	for 2 of 2 sampled clients			monthly thereafter.		
	(clients #1 and #	_			3/27/13 The Service Coordina		
	(**************************************	_).			will implement a formal training		
	Findings in dealeds				objective on privacy for clients #1		
	Findings include).			& 2 and train staff at the group		
					home on running this objective The training will be done throu		
	During the 2/5/1	3 observation period			demonstration. Staff will also be	-	
	between 5:45 AN	M and 9:40 AM, at the			trained on assisting clients' in		
	group home, clie	ent #2 dressed with her			maintaning their privacy.		
	bedroom door or	oen. Client #2 removed					
		nd bottom and put on her					
		and clothing for the day					
	•	en as the client stood near					
	_	the bedroom. No staff					
	witnessed and/or	saw client #2 get					
	dressed for the d	ay. During the entire					
		od; client #2 did not, and					
	-	ed to, communicate in her					
	home.	a to, communicate in noi					
		2 -1					
	_	3 observation period,					
		back and forth from the					
	bathroom to the	bedroom nude/without					
	any clothing mul	ltiple times from 6:29					
	AM to 7:43 AM.	•					
		-	\perp				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 15G700	A. BUILDING	00	COMPLETED 02/25/2013
		100700	B. WING	ADDRESS CITY STATE 7TD CODE	02/20/2010
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE RKANSAS AVE	
ARC OF	NORTHWEST IND			OND, IN 46323	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG	Client #1's record at 12:57 PM. Cl Individual Supportient #1 did not regard to privacy Client #2's record at 12:23 PM. Cl not indicate client training in regard communication. Interview with st PM indicated client the door open. Sher but she has to Staff #8 stated client the door open. Staff would go back at and the bathroom. Staff would go back at and the bathroom. Interview with the (SC) on 2/7/13 at was not aware client the bathroom SC indicated client the door open. SC indicated client the bathroom scanned the bathroom sca	ort Plan (ISP) indicated receive formal training in 7. d was reviewed on 2/6/13 ient #2's 8/23/12 ISP did nt #2 received formal d to privacy and taff #8 on 2/5/13 at 6:23 ent #2 would dress with staff #2 stated "We train to be redirected often." lient #1 would "normally hen going to and from the #8 indicated client #1 nd forth to her bedroom	TAG	DEFICIENCY)	DATE DATE

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	OF CORRECTION	IDENTIFICATION NUMBER: 15G700	(X2) MULTIPLE CC A. BUILDING B. WING	00	COMP 02/25	LETED 5/2013		
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP CODE 7318 ARKANSAS AVE HAMMOND, IN 46323					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE		

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Event ID: BV5F11

Facility ID: 003148

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G700		(X2) MU A. BUIL		NSTRUCTION 00	(X3) DATE S	ETED	
		15G700	B. WING	G		02/25/	2013
	PROVIDER OR SUPPLIER			7318 AF	ADDRESS, CITY, STATE, ZIP CODE RKANSAS AVE DND, IN 46323		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	(X5) COMPLETION DATE
W000231	plan must be exp that provide mean performance. Based on intervice client's Individual objectives did not criteria for comp. Findings include: Client #1's 8/15/had the following: -"[Client #1] will book to identify: 10 sessions by A: -"[Client #1] will be purchased with of the last 10 sessions: -"[Client #1] will dinner table for 10 by August 31, 20: -"[Client #1] will telephone number memory for 10 on August 31, 20:13	the individual program ressed in behavioral terms surable indices of ew and record review, the al Support Plan (ISP) of specifically include a letion for client #1. : 12 ISP indicated client #1 g objectives: I use communication needs for 10 of the last august 31, 2013." I identify items that can ch money available for 10 sions by August 31, I set her place at the 10 of the last 10 sessions 013." I write or recite her er and address from of the last 10 sessions by	Woo	00231	The IDT team will review client 1 objectives and add criteria for completion and change or more as necessary. To ensure future compliance, service Coordinat will review monthly and thereat In addition, all objectives will be modified or changed as needed or at least during the annual meeting, and staff will be trained as needed.	or dify re or fter. e	03/27/2013

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	of Correction identification number: 15G700	A. BUILDING B. WING	00	COMPLETED 02/25/2013
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	7318 AF	ADDRESS, CITY, STATE, ZIP CODE RKANSAS AVE OND, IN 46323	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E COMPLETION
	one medication for 10 of the last 10 sessions by August 31, 2013."			
	Client #1's above mentioned objectives did not include a specific criteria (prompt levels) of completion to determine when the client's objectives would be considered achieved. Interview with Service Coordinator (SC) on 2/7/13 at 9:40 AM indicated client #1's objectives did not include a percentage/criteria of completion which would determine when the client's objectives were achieved/met. 9-3-4(a)			

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STATEMEN	TEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MUL		X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED			COMPLETED	
		15G700	B. WIN			02/25/2013	
			В. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				RKANSAS AVE		
ARC OF	NORTHWEST INDI	ANA INC, THE			OND, IN 46323		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
W000240	483.440(c)(6)(i) INDIVIDUAL PRO	OGRAM PLAN					
		ogram plan must describe					
	relevant interventions to support the						
	individual toward	independence.					
		ation, interview and	W0	00240	An interm meeting will be held	 	
	record review, f	or 1 of 2 sampled clients			address client#1 ISP and will a	ıdd	
	(#1), the client's	Individual Support Plan			an addendum to include instructions on how staff at da	,	
	(ISP) did not ind	icate how facility staff			services will supervise and	′	
	were to monitor/	supervise the client at the			monitor the client to prevent cl	ient	
	day program to p	prevent the client from			from getting into the trash and		
	getting into the trash, from taking others' lunches and/or searching out food. The				from taking others lunches.		
					Instructions to get client #1 to scheduled Dr. appointments w		
		did not indicate how			be included and Behavior Sup	 	
		e to get client #1 to attend			Plan will be revised.		
	scheduled doctor	_					
		то протиготого			Service Coordinator will monitor	or	
	Findings include				client once per week for one	_	
	Tindings include	•			month and bi-weekly thereafte during lunch Service Coordina		
	1 Am abaamyatia	n was conducted at the			will monitor client as needed for	 	
					Dr. appointments.		
		ay program on 2/5/13					
		M and 1: 50 PM. At			Workshop manager retrained	al	
		t #1 walked into the			pre-voc staff on continuously monitoring all clients during lui	nch	
	_	went to the table where			time to ensure clients are not		
		ring. Client #3 gave			going through garbage, taking		
	_	t butter cracker and			others food or eating food off	the	
		the cracker into her			floor. Staff were trained on		
	mouth. Client #	l looked around the			redirecting clients if these issu occur.	es	
	dining room at th	ne other clients who were			occur.		
	already eating. A	At 12:05 PM, client #1			To ensure future compliance		
	was heating her	food up in the microwave			workshop manager and all DS		
	at the front of the	e cafeteria. Client #1			on lunch will monitor on a dail	у	
	walked by an un	identified female client			basis		
	-	lchair eating who					
		od onto the floor. Client					

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	ONSTRUCTION	COMPI	
AND PLAN	OF CORRECTION	15G700	A. BUI	LDING	00	COMPL 02/25/	
		130700	B. WIN			02/25/	۷۱۱۵
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST INDI	ANA INC, THE			RKANSAS AVE DND, IN 46323		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	#1 walked by the	e client, bent over, picked					
	the food up off the	he floor and placed it into					
	her mouth. Clien	nt #1 walked back over to					
	the microwave a	nd started looking around					
	the dining room	for food. At 12:19 PM,					
	client #1 finished	d eating and carried her					
	wrappers and pa	per up to the garbage to					
	dispose. On the	way back to her table,					
	client #1 reached	l over to an unidentified					
	male client's foo	d and attempted to take					
	the client's food.	The unidentified client					
	yelled "No" and	pulled his food toward					
	him to keep clier	nt #1 from taking it. Staff					
	#2 and #4 were i	n the dining room, staff					
	#2 and staff #4 d	lid not directly					
		se and/or redirect client					
	•	lient #1 went to the					
	staff's lounge loc	cated off the dining room					
		search for food in the					
	_	iff's lounge area. At					
		s announced it was time					
	*	prevocational area.					
	-	ed back in the dining					
		couple of minutes before					
		the workshop area.					
	•	client #1 had a cookie in					
	•	did not belong to her.					
		shop area, client #1 left					
		ea and went back to the					
	_	located off the dining					
		ne workshop did not					
	follow client #1	-					
		Client #1 was looking for					
	-	lounge area. Client #1					
	1504 III the stall						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					NSTRUCTION 00	(X3) DATE S COMPLE	
		15G700	1	LDING		02/25/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				RKANSAS AVE		
	NORTHWEST IND	·			OND, IN 46323		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
1710		return to her program		1710	·		DATE
		workshop office staff.					
	Client #1 went to the bathroom before						
		workshop area. At 12:50					
	_	ft the workshop area					
	again and return	_					
		or supervision. At 1:12					
	"	alked from her work area					
	· ·	e workshop and started					
		e trash. There were 4					
	staff in the work	shop area at that time,					
	and the workshop staff did not redirect the client from going through the trash.						
	Client #1's recor	d was reviewed on 2/6/13					
	at 12:57 PM. Cl	ient #1's 8/12 Positive					
	Behavioral Supp	ort Plan (PBSP)					
	indicated "In re	eviewing [client #1's]					
	reported behavio	ors over the past 2 years,					
	nearly 40% of th	e incidents can be traced					
	back to her atten	npts to obtain food from					
	_	cafeteria. [Client #1's]					
		y stimuli also includes					
		[client #1] does not					
		ocial norms regarding					
		sumption. She does not					
		tand sanitary issues or					
	· ·	ome items. She may take					
	_	rbage" Client #1's					
		"While observing					
	-	s (sic) ample personal					
		not like to be followed, so					
		a safe distance" Client					
	#1's PBSP in reg	ard to digging in the					

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	OF CORRECTION	IDENTIFICATION NUMBER: 15G700	A. BUILDING 00			COMPLETED 02/25/2013	
		150700	B. WIN			02/23/	2013
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST INDI	ANA INC, THE			RKANSAS AVE DND, IN 46323		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
1110		d, "After food items are	+	1710			DATE
		e trash, especially if these					
	•	hy to eat (raw meats,					
		garbage bag should be					
		oved to an outside					
	•	at [client #1] has less					
		at #1's 8/12 PBSP did not					
	indicate how faci	•					
	•	e client #1, at the day					
		ent the client from					
		g out food, taking food					
		e lunch room, and/or to					
	-	om digging through					
	trash/garbage.						
	Interview with st	aff #2 on 2/5/13 at 12:40					
	PM indicated clie	ent #1's behavior had					
		lay program. Staff #2					
	_	to keep a close eye on					
	her."	1					
	Interview with th	e Service Coordinator					
		t 9:40 AM indicated					
	` '	d supervision and					
	_	workshop to prevent the					
	_	g food and/or digging in					
		e. The SC indicated					
		used to indicate how					
		e to monitor the client.					
	The SC indicated						
		itoring would need to be					
	_	the client's PBSP.					
	placed back into	and entitles i Doi .					
	2. Client #1's red	cord was reviewed on					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G700	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM	TE SURVEY SPLETED 25/2013
	PROVIDER OR SUPPLIER		7318 A	ADDRESS, CITY, STATE, ZIP CO RKANSAS AVE OND, IN 46323	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	2/6/13 at 12:57 F Record indicated	PM. Client #1's Medical I the following:				
	_	#1] had a dental appt day. Refused. It will be				
	-5/11/12 "[Clien mammogram apple re-scheduled.	pointment today. It will				
	-6/8/12 "[Client (mammogram) to rescheduled."	#1] refused her Mammo oday. Will be				
	COOPERATE F	atient) REFUSED TO OR MAMMOGRAM. O TEST DUE TO PT'S N."				
		I mammo today. Service Coordinator. 7-16-12 at 2:00 p.m."				
		used her eye exam unable e to [client #1] fighting at her staff."				
	-12/4/12 "Consu be x-rayed."	mer (client #1) refused to				
	-1/2/13 "[Client cxr (chest x-ray)	#1] refused to go on her appt."				

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	TOF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G700	(X2) MU A. BUII B. WIN	DING	NSTRUCTION 00	(X3) DATE COMPL 02/25/	ETED
	PROVIDER OR SUPPLIER		<i>D.</i> WII.	STREET A	DDRESS, CITY, STATE, ZIP CODE RKANSAS AVE DND, IN 46323		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	-1/25/13 "[Client Px (physical exa	#1] refused her annual mination)."					
	indicated client #	1/11 doctor's prescription f1 required a chest xray positive PPD (mantoux					
	Plan (ISP) indicated objective to "re 80% independent sessions by Augumethodology individual week staff will define the importance of appointments. So such as 'Why is indoctor?(sic)''V appointment?''V appointment?''V appointment?''V regular doctor vineurologist appointment ablood to cardiologist appointment #1's 8/15/8/12 PBSP did in how and/or what to assist client #1's appointment on the staff of	12 Individual Support ated client #1 had an espond appropriately with ce for 10 of the last 10 ast 31, 2013." Client #1's licated "Three times per iscuss with [client #1] f attending doctor's taff will ask questions apportant to go to the Who takes you to the Staff will explain what a sit is like, what a intment is like, what est is like, and what a bintment is like" 12 ISP objective and/or of specifically indicate facility staff were to do attend her doctor's the scheduled day.					
	(SC) on 2/7/13 a client #1 refused	ne Service Coordinator t 9:40 AM indicated to attend doctors' the SC indicated client					

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PRINTED: 04/04/2013 FORM APPROVED OMB NO. 0938-0391

	of Correction identification number: 15G700	A. BUILDING B. WING	00	COMPI - 02/25	
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	7318 AI	ADDRESS, CITY, STATE, ZIP CO RKANSAS AVE OND, IN 46323	DE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	#1's ISP and/or PBSP did not indicate how staff were to assist the client to attend scheduled appointments when they came up. The SC indicated the SC was going to try and take client #1 to her rescheduled physical examination appointment at the end of February and if that did not work, the client's mother would take the client to the doctor. 9-3-4(a)				

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G700		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/25/2013	
	ROVIDER OR SUPPLIER		7318 A	ADDRESS, CITY, STATE, ZIP CODE NRKANSAS AVE OND, IN 46323	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
W000249	formulated a clier each client must in treatment program interventions and number and frequachievement of the individual program interview, the factories written objective opportunity for 2 (clients #1 and #4). Findings include A morning observed the group home of AM and 8:40 AM client #1, who has skills, was not expended the majority and forth to the bedroom and/or Facility staff #9 at the client to finise to set her own plus breakfast. Once obathing and dress staff did not program interventions and discovered the staff did not program interventions.	terdisciplinary team has the individual program plan, receive a continuous active in consisting of needed services in sufficient tency to support the te objectives identified in tegram plan. The individual program plan is during times of the of 2 sampled clients 2.)	W000249	Group home staff will be trained on implementing active treatments activities To ensure future compliance, Service Coordinator will monitive weekly for one month and bi-weekly thereafter. Workshop manager retrained Pre-Voc staff on running goals/objectives whether form or informal at all times of opportunity. Work shop managhas also trained all Pre-Voc ston keeping clients focused on production or other programm activities. To ensure future compliance, workshop manager will monitor on a daily basis, and Service Coordinator will monitor on a monthly basis.	al ger taff

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G700		LDING	NSTRUCTION 00	(X3) DATE COMPL 02/25	ETED	
	PROVIDER OR SUPPLIER		STREET A	DDRESS, CITY, STATE, ZIP CODE RKANSAS AVE DND, IN 46323		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B: CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		(X5) COMPLETION DATE
	staff #9 and #10	e in her home. Facility would check on client #2 pt her to any meaningful				
	was conducted of A.M. until 1:50 I until 12:00 P.M. with a wooden of front of her. Clicand was not pror 11:50 AM, client dining room and client #3 was sittle client #1 a peanu client #1 placed mouth. Client # dining room at the already eating. Was heating her at the front of the walked by an un sitting in a whee dropped some for #1 walked by the the food up off the microwave at the dining room client #1 finished wrappers and pardispose. On the	day program observation in 2/5/13 from 11:15 P.M. From 11:15 A.M., client #2 sat at a table hildren's puzzle sitting in ent #2 sat with no activity inpted to any activity. At it #1 walked into the went to the table where sing. Client #3 gave it butter cracker and the cracker into her il looked around the ne other clients who were At 12:05 PM, client #1 food up in the microwave is cafeteria. Client #1 identified female client lichair eating who hod onto the floor. Client is client, bent over, picked the floor and placed it into int #1 walked back over to ind started looking around for food. At 12:19 PM, if eating and carried her per up to the garbage to way back to her table, if over to an unidentified				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MI	JLTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		15G700	B. WIN			02/25/	2013
NAME OF F	PROVIDER OR SUPPLIEF	\ \			ADDRESS, CITY, STATE, ZIP CODE		
ADC 05	NODELIMECT IND	IANIA INIC. THE			RKANSAS AVE		
	NORTHWEST IND	IANA INC, THE		HAIMING	OND, IN 46323		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	ΓE	COMPLETION DATE
TAG		d and attempted to take		TAG	BETTELLINETY		DATE
		*					
	the client's food. At 12:45 P.M., client #1 walked out of the workshop area down						
	the hall and went into the staff's lunch						
	room. Client #1 dug into the garbage can and grabbed something out of it and put it						
	in her mouth and ate it. At 1:15 P.M.,						
	client #1 walked out of the workshop area						
	to the front office area and dug into a						
	garbage can, grabbed an empty candy bar paper, smelled it and put it back into the						
	trash can.						
	During the 2/5/1	3 observation period					
	~	A and 6:50 PM, at the					
		ent #1 independently					
		room and mopped the					
		ining, prompts and/or					
	redirection from	0.1					
	realisection from	our.					
	Client #1's recor	d was reviewed on 2/6/13					
		ient #1's 8/15/12					
		ort Plan (ISP) indicated					
		jectives to use her					
	ľ	book, to clean the					
		er stall, and an objective					
		at the dining room table.					
		and #9 did not implement					
	,	e mentioned objectives					
		l/or informal training					
	opportunities ex	•					
	Client #1's 8/12	Positive Behavioral					
	Support Plan (Pl	BSP) indicated "Once					
	Support Flair (Fl	Joi / IlluicatedOlice					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G700		A. BUILDING B. WING			COMPLETED 02/25/2013		
NAME OF I	PROVIDER OR SUPPLIER		B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST INDI	ANA INC, THE			OND, IN 46323		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TE	(X5) COMPLETION DATE
TAG	[client #1] has fir be encouraged to another activity propers or staff ment fond (sic). She in the cleaning crew listening to music Regardless she shomething else rate focus on what off with food" A review of client conducted on 2/6 #2's ISP dated 8/2 following training participate in a get to identify coins, quarterWill inconfitness activity." Interview with the (SC) on 2/7/13 and communication be objective to clear stall. The SC inconstall. The SC inconstall. The SC inconstall incompared to the client was able to bathroom independent another than the client #1 to another client #	nished eating she should become involved in bossible visiting with mbers for which she is may enjoy being part of w, or she may enjoy c or looking at pictures. hould be redirected to do ather than be allowed to hers are eating or doing at #2's record was w/13 at 12:23 P.M. Client 23/12 indicated the g objectives: "Will roup activityWill learn penny, nickel, dime, rease participation in the Service Coordinator to 9:40 AM indicated objective to use her book when needed and an an the bathroom shower dicated facility staff sted and/or taught the the shower stall as the to clean other parts of the		TAG	DEFICIENCY)		DATE

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PRINTED: 04/04/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION OF CORRECTION 15G700	(X2) MULTIPLE CO A. BUILDING B. WING	00	— COM 02/2	e survey pleted 5/2013		
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 7318 ARKANSAS AVE HAMMOND, IN 46323					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE		
	implemented at the facility's owned day program/workshop. The SC further indicated staff should implement clients' training objectives "at all times of opportunity." 9-3-4(a)						

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Event ID: BV5F11

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TAG	STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE ARC OF NORTHWEST INDIANA INC, THE STREET ADDRESS, CITY, STATE, ZIP CODE 7318 ARKANSAS AVE HAMMOND, IN 46323 D REGISTATION OR ISC IDENTIFYING INFORMATION) W000257 483.440(f)(1)(ii) Professional (QMRP) failed mental retardation professional and revised as necessary, including, but not limited to situations in which the client is failing to progress toward identified objectives after reasonable efforts have been made. Based on interview and record review, the Clients (client #1), to revise the client's objectives after no progress had been made. Findings include: 1. Client #1's record was reviewed on 2/6/13 at 12:57 PM. Client #1's Medical Record indicated the following: -1/30/12"[Client #1] had a dental appt (appointment) today. Refused. It will be rescheduled." -6/8/12 "[Client #1] refused her mammogram appt today. It will be re-scheduled." -6/8/12 "[Client #1] refused her Mammo	AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A DIII	DINC	00	COMPL	ETED
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE INCIDIATORY OR IS DEPTITION OF DEPTICENCY INCIDIATORY OR IS DEPTITION INDIANATION WO00257 ASSUMPTION OF THE PRACEDED BY FULL TAG REGULATORY OR IS DEPTITION INDIANATION WO00257 ASSUMPTION INCIDIATORY OF THE PRACEDED BY FULL TAG REGULATORY OR IS DEPTITION INDIANATION WO00257 ASSUMPTION IN THE PRACEDED BY FULL TAG REGULATORY OR IS DEPTITION INDIANATION WO00257 ASSUMPTION IN THE PRACEDED BY FULL TAG REGULATORY OR IS DEPTITION INDIANATION WO00257 ASSUMPTION IN THE PRACEDED BY FULL TAG REGULATORY OR IS DEPTITION INDIANATION WO00257 ASSUMPTION IN THE PRACEDED BY FULL TAG REGULATORY OR IS DEPTITION IN THE PRACEDED BY FULL TAG REGULATORY OR IS DEPTITION IN THE PRACEDED BY FULL TAG WO00257 COMPLETION DATE WO00257 Client # 1 objective will be reviewed and revised by The IDT team. To ensure future compliance, Service Coordinator will review on the reviewed and revised by The IDT team. To ensure future compliance, Service Coordinator will review on the reviewed and revised by The IDT team. To ensure future compliance, Service Coordinator will review on wonthly and thereafter. In addition, all objectives will be modified or changed as needed or at least at the annual meetings. Findings include: 1. Client #1's record was reviewed on 2/6/13 at 12:57 PM. Client #1's Medical Record indicated the following: -1/30/12"[Client #1] had a dental appt (appointment) today. Refused. It will be rescheduled." -5/11/12 "[Client #1] refused her mammogram appt today. It will be re-scheduled." -6/8/12 "[Client #1] refused her Mammo			15G700				02/25/	2013
ARC OF NORTHWEST INDIANA INC, THE ARC OF NORTHWEST INDIANA INC, THE SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PROPRIET TAG REGULATORY OR LSC IDENTIFYING INFORMATION) AS 3.440([n](iii) PROGRAM MONITORING & CHANGE The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is failing to progress toward identified objectives after reasonable efforts have been made. Based on interview and record review, the Qualified Mental Retardation Professional (QMRP) failed for 1 of 2 sampled clients (client #1), to revise the client's objectives after no progress had been made. Findings include: 1. Client #1's record was reviewed on 2/6/13 at 12:57 PM. Client #1's Medical Record indicated the following: -1/30/12"[Client #1] had a dental appt (appointment) today. Refused. It will be rescheduled." -5/11/12 "[Client #1] refused her mammogram appt today. It will be re-scheduled." -6/8/12 "[Client #1] refused her Mammo				B. WIIV		ADDRESS CITY STATE 7ID CODE		
ARC OF NORTHWEST INDIANA INC, THE IXAMID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES REGULATORY OR LSC DENTIFYING ENFORMATION) TAG W000257 AB3.440(f)(1)(ii) PROGRAM MONITORING & CHANGE The individual program plan must be reviewed at least by the qualified mental retardation professional and review as a necessary, including, but not limited to situations in which the client is falling to progress toward identified objectives after reasonable efforts have been made. Based on interview and record review, the Qualified Mental Retardation Professional (QMRP) failed for 1 of 2 sampled clients (client #1), to revise the client's objectives after no progress had been made. Findings include: 1. Client #1's record was reviewed on 2/6/13 at 12:57 PM. Client #1's Medical Record indicated the following: -1/30/12"[Client #1] had a dental appt (appointment) today. Refused. It will be rescheduled." -6/8/12 "[Client #1] refused her mammogram appt today. It will be re-scheduled."	NAME OF P	ROVIDER OR SUPPLIER	8					
PREFIX TAG W000257 W000257 W000258 W000259 Client #1 objective will be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is failing to progress toward identified objectives after reasonable efforts have been made. Based on interview and record review, the Qualified Mental Retardation Professional (QMRP) failed for 1 of 2 sampled clients (client #1), to revise the client's objectives after no progress had been made. Findings include: 1. Client #1's record was reviewed on 2/6/13 at 12:57 PM. Client #1's Medical Record indicated the following: -1/30/12"[Client #1] had a dental appt (appointment) today. Refused. It will be rescheduled." -5/11/12 "[Client #1] refused her mammogram appt today. It will be re-scheduled." -6/8/12 "[Client #1] refused her Mammo	ARC OF I	NORTHWEST INDI	IANA INC, THE					
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG	(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	1	ID	NO CURRENCE NO LOCAL CONTRACTION		(X5)
W000257 Client # 1 objective will be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is failing to progress toward identified objectives after reasonable efforts have been made. Based on interview and record review, the Qualified Mental Retardation Professional (QMRP) failed for 1 of 2 sampled clients (client #1), to revise the client's objectives after no progress had been made. Findings include: 1. Client #1's record was reviewed on 2/6/13 at 12:57 PM. Client #1's Medical Record indicated the following: -1/30/12"[Client #1] had a dental appt (appointment) today. Refused. It will be rescheduled." -5/11/12 "[Client #1] refused her mammogram appt today. It will be re-scheduled." -6/8/12 "[Client #1] refused her Mammo	PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	T-	COMPLETION
PROGRÀM MONITORING & CHANGE The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is failing to progress toward identified objectives after reasonable efforts have been made. Based on interview and record review, the Qualified Mental Retardation Professional (QMRP) failed for 1 of 2 sampled clients (client #1), to revise the client's objectives after no progress had been made. Findings include: 1. Client #1's record was reviewed on 2/6/13 at 12:57 PM. Client #1's Medical Record indicated the following: -1/30/12"[Client #1] had a dental appt (appointment) today. Refused. It will be rescheduled." -5/11/12 "[Client #1] refused her mammogram appt today. It will be re-scheduled." -6/8/12 "[Client #1] refused her Mammo	TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	16	DATE
(mammogram) today. Will be rescheduled." -6/22/12 "PT (patient) REFUSED TO COOPERATE FOR MAMMOGRAM.		483.440(f)(1)(iii) PROGRAM MON The individual pro reviewed at least retardation profes necessary, include situations in whice progress toward is reasonable efforts Based on intervicy Qualified Menta Professional (QN sampled clients (client's objective been made. Findings includes 1. Client #1's rec 2/6/13 at 12:57 F Record indicated -1/30/12"[Client (appointment) to rescheduled." -5/11/12 "[Client (appointment) to rescheduled." -6/8/12 "[Client (mammogram appre-scheduled." -6/8/12 "[Client (mammogram) to rescheduled."	IITORING & CHANGE by the qualified mental ssional and revised as ling, but not limited to h the client is failing to identified objectives after s have been made. ew and record review, the I Retardation MRP) failed for 1 of 2 (client #1), to revise the es after no progress had E: cord was reviewed on PM. Client #1's Medical d the following: #1] had a dental appt oday. Refused. It will be at #1] refused her pt today. It will be #1] refused her Mammo oday. Will be	W0		Client # 1 objective will be reviewed and revised by The I team. To ensure future compliance, Service Coordina will review monthly and therea In addition, all objectives will b modified or changed as neede	tor ifter. ed	03/27/2013

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Event ID: BV5F11

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G700		(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00	COM	e survey pleted 5/2013	
	PROVIDER OR SUPPLIER		7318 AF	ADDRESS, CITY, STATE, ZIP CO RKANSAS AVE DND, IN 46323		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	UNABLE TO D COOPERATION	O TEST DUE TO PT'S N."				
		I mammo today. Service Coordinator. 7-16-12 at 2:00 p.m."				
		used her eye exam unable e to [client #1] fighting at her staff."				
	-12/4/12 "Consumer refused to be x-rayed."					
	-1/2/13 "[Client cxr (chest x-ray)	#1] refused to go on her appt."				
	-1/25/13 "[Clien Px (physical exa	t #1] refused her annual mination)."				
	indicated client #	9/11 doctor's prescription #1 required a chest X-ray positive PPD (Mantoux				
	Plan (ISP) indicated objective to "re 80% independent sessions by August Progress Notes Summaries) indicated objective to "re 80% independent sessions by August Progress Notes Summaries) indicated objective to "re 80% independent sessions by August Progress Notes Summaries objective to "re 80% independent sessions by August Progress Notes Summaries objective to "re 80% independent sessions by August Progress Notes Summaries objective to "re 80% independent sessions by August Progress Notes Summaries objective to "re 80% independent sessions by August Progress Notes Summaries objective to "re 80% independent sessions by August Progress Notes Summaries objective to "re 80% independent sessions by August Progress Notes Summaries objective to "re 80% independent sessions by August Progress Notes Summaries objective to "re 80% independent sessions by August Progress Notes Summaries objective to "re 80% indicated by "re 80% ind	12 Individual Support ated client #1 had an espond appropriately with ce for 10 of the last 10 ust 31, 2013. Client #1's Summary (monthly cated the following:				
	December 2012	- 38 to 41.4%				

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		00	(X3) DATE (COMPL	
		15G700	B. WIN			02/25/	2013
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST INDI	ANA INC, THE			RKANSAS AVE DND, IN 46323		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	November 2012	- 37.5% to 42%					
	October 2012 - no data						
	September 2012 8/15/12 ISP did thad revised the clack of progress. Interview with the (SC-QMRP) on the indicated client # doctor appointm	- 51.9% Client #1's not indicate the QMRP client's objective due to					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G700		(X2) MULTIPLE C A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/25/2013	
		130700	B. WING		02/23/2013
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
ARC OF	NORTHWEST INDI	ANA INC, THE		IOND, IN 46323	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
W000315	483.450(e)(4)(i) DRUG USAGE				
	Drugs used for co behavior must be desired response consequences by	facility staff.	W000315	One # 444	03/27/2013
		review and interview, the	W000313	See # 111	03/2//2013
		provide evidence of			
	•	ning for extrapyramidal			
	•	ychoactive medications			
	•	ed clients (client #2) and			
	1 additional client (client #3) who received psychotropic medications.				
	received psychot	ropic medications.			
	Findings include	:			
	conducted on 2/6 review of her Ph 1/28/13, indicate Thiothixene as a disease. No evid record to docume	nt #2's record was 5/13 at 12:23 P.M A ysician's order dated d she was prescribed treatment for bipolar lence existed in the ent ongoing screening for ide effects of the use of			
	the surveyor with identified as a sc side effects of ps that was given to provide to the su was labeled, "Branch Pressure Sore Ri	O P.M., the SC provided in a document which she reening document for sychoactive medication other by the nurse to rveyor. The document aden Scale for Predicting sk" and included a prevaluate skin integrity			

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PRINTED: 04/04/2013 FORM APPROVED OMB NO. 0938-0391

	of Correction identification number: 15G700	A. BUILDING B. WING	00 	COMPLETED 02/25/2013
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	7318 AF	ADDRESS, CITY, STATE, ZIP CODE RKANSAS AVE DND, IN 46323	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E COMPLETION
	issues. No evidence of screening for extrapyramidal side effect of psychoactive medication was provided.			
	A review of client #3's record was conducted on 2/6/13. Her physician's order dated 1/6/13, documented she was prescribed Saphris as a treatment for bipolar disorder. No evidence existed in the record to document ongoing screening for extrapyramidal side effects of the use of Saphris.			
	On 2/6/13 at 1:15 P.M. and interview was initiated with Staff #7, the Licensed Practical Nurse assigned to monitor the health of the people in the facility. She verified the absence of ongoing screening for extrapyramidal side effects of psychoactive medication for Client #3. She said the psychiatrist screened patients for extrapyramidal side effects of psychoactive medications at annual and semi-annual appointments. She said the psychiatrist used the AIMS (Abnormal Involuntary Movement Scale) to conduct the screenings. She verified the screening documents were not in the client records, adding the documents were on her desk.			
	9-3-5(a)			

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLI	ETED
		15G700	B. WIN			02/25/	2013
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				RKANSAS AVE		
ARC OF	NORTHWEST INDI	ANA INC, THE	HAMMOND, IN 46323				
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W000322	and general medibased on record facility failed to current annual plus clients (client #1 Findings include Client #1's record at 12:57 PM. Client #1 did not examination in hwas dated 12/14/signed physician #1 received routi (Zoloft-behavior Losartan-HCTZ-#1's 12/12 orders allergic to bees a (allergic reaction Interview with the (SC) on 2/7/13 a client #1 did not examination. The	provide or obtain preventive ical care. review and interview the provide evidence of a hysical for 1 of 2 sampled). d was reviewed on 2/6/13 ient #1's record indicated have a current physical ier record as the last one /11. Client #1's 12/12 's orders indicated client	WO	00322	Client # 1 physical is schedule for 4/8/13 To ensure future compliance, Service Coordina will add an addendum to client Behavior Plan to include instructions for getting client # her scheduled appointments.Service Coordinator will monitor all scheduled appointments for compliance, and attend appointments if necessary.	tor ts	03/27/2013

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 15G700				LDING	00	(X3) DATE (COMPL 02/25 /	ETED
NAME OF P	ROVIDER OR SUPPLIER		•		ADDRESS, CITY, STATE, ZIP CODE RKANSAS AVE		
ARC OF I	NORTHWEST INDI	ANA INC, THE			OND, IN 46323		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
W000362	483.460(j)(1) DRUG REGIMEN A pharmacist with interdisciplinary to regimen of each of Based on record agency nursing squarterly pharma and reviewed by of 4 clients who (clients #1, #2, # Findings include Client #1's record at 12:57 PM. Cliphysician's order received routine consisted of Ferr Losartan-Hydroc pressure) and Sec Client #1's record pharmacy review regard to the clie calendar year of A review of client conducted on 2/6 Client #2's most dated 2/13 indicated medications while the transport of the client of the client for the client f	REVIEW Input from the sam must review the drug client at least quarterly. The review and interview the staff failed to assure acy reviews were obtained the physician affecting 4 lived in the facility 3 and #4). In the facility 3 and #4 in the fa	WO	00362	See # 104		03/27/2013

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Facility ID: 003148

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G700	ĺ	LDING	NSTRUCTION 00	(X3) DATE COMPL 02/25/	ETED
	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE RKANSAS AVE DND, IN 46323		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) ea). Review of the		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		(X5) COMPLETION DATE
	record did not in pharmacy review	dicate quarterly vs had been conducted in ent's medications for the					
	for Client #3. H dated 1/6/13, doo prescribed medic Loratadine, Med Metoprolol, Nab Saphris, Tizanid Pseudoephedrine include a quarter	roxyprogesterone, umetone, Potassium, ine, and e. The record did not rly drug regimen review e pharmacist for the					
	conducted on 2/6 Review of client physician's order received routine consisted of Div Fluticasone (nas (seizures), Folic Oxcarbazepine ((pain), Maalox (Pseudoephedrine Review of client indicate quarterly been conducted	acid (anemia), seizures), Acetaminophen					

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	OF CORRECTION	IDENTIFICATION NUMBER: 15G700	A. BUILDING B. WING	00 	ON	COMPL 02/25/	ETED
	PROVIDER OR SUPPLIER		73 ⁻	EET ADDRESS, C 18 ARKANSAS MMOND, IN 4			
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) 50 a.m. an interview was	ID PREFI TAC	X (EACH C	COVIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	initiated with the She reported the evidence of the r pharmacy review facility. She exp had experienced quarterly pharma failures in nursing	e Director of Nursing. agency did not have required quarterly ws for the residents of the blained that the agency failures in obtaining acy review reports and ag staff follow up to s were received and					

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Event ID: BV5F11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED	
		15G700	A. BUII B. WIN			02/25/	2013
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF P	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP CODE		
ADC 05		IANIA INC. THE			RKANSAS AVE		
ARC OF	NORTHWEST INDI	IANA INC, THE		HAIVIIVIC	OND, IN 46323		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
TAG W000369	483.460(k)(2) DRUG ADMINIST The system for dr assure that all dru are self-administe without error. Based on observ record review, the all medications we without error for administered for Findings include During the 2/5/1 between 5:45 AM group home, staft Fluticasone Nasa spray, in each no Client #2's Febru Administration Freviewed on 2/5/ #2's February 20 #2 was to receive 2 sprays in each Client #2's record at 12:23 PM. Cl physician's order to receive "Flution	TRATION rug administration must rugs, including those that ered, are administered ation, interview and he facility failed to ensure were administered 1 of 16 doses client #2. 3 observation period M and 8:40 AM, at the ff #9 administered hal Spray (allergies), 1 hostril of client #2. hary 2013 Medication Record (MAR) was 13 at 8:14 AM. Client hal MAR indicated client he Fluticasone Nasal Spray hostril daily. d was reviewed on 2/6/13 hient #2's December 2012 he indicated client #2 was he casone Propos he rays in each nostril once	Wo	00369	Community Services Nurse wi train DSP on administering Fluticasone nasel spray to clie #2 as directed. To ensure futur compliance, Community Servic nurse or Service Coordinator with monitor weekly for 1 month an bi-monthly thereafter.	nt e ces vill	03/27/2013
	Interview with st	taff #9 on 2/5/13 at 8:20					

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	of Correction identification number: 15G700	(X2) MULTIPLE CC A. BUILDING B. WING	00 	COMPLETED 02/25/2013
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	7318 AI	ADDRESS, CITY, STATE, ZIP CODE RKANSAS AVE OND, IN 46323	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE COMPLETION
	AM indicated client #2's Fluticasone label and MAR indicated 2 sprays in each nostril. Staff #9 indicated she administered 1 spray in each nostril. Staff #2 indicated she thought the facility nurse had told her to administer 2 sprays in each nostril during the allergy season and 1 spray in each nostril during the winter months. Staff #9 stated "I may have got clients mixed up." 9-3-6(a)			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G700		A. BUII	LDING	ONSTRUCTION 00	(X3) DATE : COMPL 02/25/	ETED	
	PROVIDER OR SUPPLIER		B. WIN	7318 AI	ADDRESS, CITY, STATE, ZIP CODE RKANSAS AVE DND, IN 46323		
(X4) ID PREFIX TAG	SUMMARY S' (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	·ΤΕ	(X5) COMPLETION DATE
W000440	483.470(i)(1) EVACUATION DETACUATION DESCRIPTION DESCRIPTION DESCRIPTION DETACUATION DESCRIPTION DESCRIPTION DESCRIPTION DETACUATION DESCRIPTION DE L'ASTAULTE DE	RILLS mold evacuation drills at each shift of personnel. review and interview, the conduct evacuation drills staff shift (11:00 P.M. to ag the second quarter h June 30th) and no drills arter (October 1st er 31st) of 2012 which ients living in the facility 3 and #4).	Woo	00440	Group home staff will be re-trained by area manager or conducting fire drills every moshift 7-3; 3-11; 11-7, and to document in fire drill folder. Tensure future compliance, stawill send in fire drill folder to A Manager every Monday for review.	onth, o ff	03/27/2013

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PRINTED: 04/04/2013 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER: 15G700	A. BUILDING B. WING	00 	COMPLETED 02/25/2013
	ROVIDER OR SUPPLIER		7318 A	ADDRESS, CITY, STATE, ZIP CODE RKANSAS AVE OND, IN 46323	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	P.M. and 11:00 I	P.M. to 7:00 A.M. shifts.			
)				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
		15G700	B. WIN	G		02/25/2013	
NAME OF P	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					RKANSAS AVE		
ARC OF	NORTHWEST INDI	IANA INC, THE		HAMM	OND, IN 46323		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		
TAG W000455		LSC IDENTIFYING INFORMATION)	+-	TAG	DEFICIENCY)	DATE	
VVUUU433	483.470(I)(1) INFECTION CON	JTROI					
		active program for the					
		ol, and investigation of					
		nmunicable diseases.					
		ation, record review and	$ W_0$	00455	The Health and Safety Tech have trained all staff on infection	as 03/27/2013	
		cility failed to maintain			re-trained all staff on infectin control, cross contamination, a	and	
		practices and prevent			the use of gloves.Gloves will b	I	
		tion, during mealtime.			available at health and Safety		
		the potential to affect all			Tech's office, in the cafeteria a	I	
	_	the workshop (clients #1,			the kitchen area during lunch to for staff to use as needed. To	ime	
	#3 and #4).				ensure future compliance, Hea	alth	
					and Safety Tech will monitor o	I	
	Findings include	:			daily basis and train staff as		
					needed. New staff will be train	ed	
		15 a.m. an observation			before they start working.		
	was initiated in t	he lunch room at the					
	1	orkshop. Client #3 sat at					
	a dining table ear	ting her lunch. During					
	the meal, drool s	pilled from her mouth					
	onto the table. S	staff #2 (Direct Support					
	Professional) app	proached the table and					
	wiped up the dro	ool spill with a rag. She					
	wore latex glove	s on each hand. Three					
	clients (not in the	e sample) sat at the					
	adjacent table an	d one of them spilled					
	food from his pla	ate onto the table between					
	them. Staff #2 n	noved to that table and					
	wiped up the spi	lled food with the same					
	rag and same glo	oves. Staff #2 then					
	moved to the pas	ss through counter					
	between the dini	ng room and the kitchen					
	where she leaned	d with her back to the					
	counter as she w	atched the activity in the					
	dining room. As	s she stood watching, she					

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	OF CORRECTION	IDENTIFICATION NUMBER: 15G700	A. BUILDING B. WING			COMPLETED 02/25/2013	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				RKANSAS AVE		
	NORTHWEST INDI	·		<u> </u>	OND, IN 46323		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	,	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
1710		d hands on the counter		1710	<u> </u>		DATE
	-	er fingers against the					
	underside of the						
		ve from client to client,					
		eal time supports without					
	changing her glo						
		Client #1 approached					
	*	2 raised her right hand					
	· ·	give Client #1 a "high					
	five" onto Client	,					
	On 2/5/13 at 12:3	30 p.m. an interview was					
	initiated with Sta	iff #2. She reported she					
	wore gloves to,	"Keep her hands clean."					
	She indicated that	nt the gloves were worn					
	for sanitation. W	hen the observations of					
	failure on her par	rt to change the gloves					
	before coming in	to contact with different					
	clients and the "	high five " given with					
	contaminated glo	oves, she responded,					
	"You are right, I	didn't change them, but I					
		asked if she received					
	training on the us	se of latex gloves, she					
	said she had beer	n trained sometime in the					
	past, but was not	sure when she received					
	that training.						
	On 2/5/13 at 1:00) p.m. an interview was					
		of p.m. an interview was					
		the workshop. She					
	<u>-</u>	red as the trainer for the					
	•	alth/safety related topics.					
		ned the staff annually on					
		itions. She said it had					

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	of Correction identification number: 15G700	(X2) MULTIPLE CO A. BUILDING B. WING	00	COMPL 02/25	ETED
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	7318 AF	ADDRESS, CITY, STATE, ZIP CODE RKANSAS AVE OND, IN 46323	-	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E	(X5) COMPLETION DATE
	been about 12 months since the previous training. She indicated that she discussed the purpose and use of latex gloves in her Universal Precautions training. Staff #5 said she had little opportunity to do continuing observation and training on the staff's use of latex gloves during the mealtime, due to her other duties including passing medications at midday. On 2/7/13 the facility provided records of the subject matter for the Universal Precautions training. These training documents included no written information about the appropriate use of latex gloves. The training materials included a picture of woman holding her hand up, wearing a latex glove on her hand. 9-3-7(a)				

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	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00		
		15G700	B. WIN	G		02/25/	2013
NAME OF P	ROVIDER OR SUPPLIER			I	ADDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST INDI	ANA INC, THE			ARKANSAS AVE IOND, IN 46323		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	DE OVERENDE DE LOS CONTRACTOS		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W000488	483.480(d)(4) DINING AREAS AThe facility must a in a manner considevelopmental level Based on observation facility failed to a residing at the graph and #4) assist. Findings include A morning observation facility failed to a residing at the graph and facility failed to a residing at the graph and #4) assist. Findings include A morning observation for the group home of until 8:45 A.M. Support Professioneggs and cooked client #2 sat with A.M., clients #1, independently. Odid not assist in resident facility of the facilit	AND SERVICE assure that each client eats istent with his or her wel. ation and interview, the assure 4 of 4 clients roup home (clients #1, #2, ed in meal preparation. : rvation was conducted at the properties of the service on a (DSP) #9 boiled sausage patties while in no activity. At 6:50 #2, #3 and #4 ate clients #1, #2, #3 and #4 meal preparation. the the Service of the was conducted on A.M. The SC indicated able of assisting in meal further indicated they	Wo	00488	Group home staff will be trained on encouraging clients to participate in meal preparation the extent of their abilities. This training will be done through demonstration. To ensure futue compliance, Service Coordinate will monitor weekly for one monand monthly thereafter.	n to is ire tor	03/27/2013

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PRINTED: 04/04/2013 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA DF CORRECTION IDENTIFICATION NUMBER: 15G700	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM 02/2	e survey pleted 5/2013
	ROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	7318 Al	ADDRESS, CITY, STATE, ZIP CO RKANSAS AVE DND, IN 46323	DDE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE

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